

## MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-010077

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUD

AMENDED

Registration District No. 381 Primary Registration District No. 4515 Registrar's No. 15

FILED FEB 19 1963

VS 300  
Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Sullivan</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Grundy</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Melan</u>		c. CITY OR TOWN <u>Dunlap</u>	
Length of stay in 1b <u>2 days</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>SCM Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>Henton Route 2</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOHN CHARENCE HAMILTON</u>		4. DATE OF DEATH Month Day Year <u>2-8-1963</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>11-28-1898</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Chicago Ill</u>	
11. BIRTHPLACE (City and state or country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>James M Hamilton</u>		13b. MOTHER'S MAIDEN NAME <u>Elyse Smith</u>	
14. NAME OF HUSBAND OR WIFE <u>Lillian Harte</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>47</u>		17. INFORMANT <u>Mrs Lillian Hamilton Henton Mo</u>	
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia, anoxia death</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Pulmonary Infiltration</u> DUE TO (c) <u>Myocardial Infarction</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 hours</u> <u>3 days</u> <u>Feb 4-63</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home; farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE		
21. I attended the deceased from <u>Dec 1959</u> to <u>Feb 8-63</u> and last saw her alive on <u>Feb 8-63</u> Death occurred at <u>6: P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Art Eitel</u> (Degree or title)		22b. ADDRESS <u>Salt Missouri</u>	
22c. DATE SIGNED <u>2-9-63</u>		22d. LOCATION (City, town, or county) (State) <u>Henton Mo</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>2-11-1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Catholics Cemetery</u>	
24. FUNERAL DIRECTOR <u>Payne Funeral Home</u>		25. DATE RECD. BY LOCAL REG. <u>2-11-63</u>	
26. REGISTRAR'S SIGNATURE <u>Mrs. M. W. Beckett</u>			

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK  
OR  
TYPEWRITER RIBBON

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed \_\_\_\_\_

*PA Byrne J*

Licensed Embalmer No. 3400

P. O. Address Salt

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.